Texas Department of Insurance, Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1609

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

PART I: GENERAL INFORMATION

Requestor's Name and Address:	MFDR Tracking #: M4-10-3587-01
	DWC Claim #:
	Injured Employee:
Respondent Name and Box #: AMERICAN CASUALTY CO OF READING Box #: 47	Date of Injury:
	Employer Name:
	Insurance Carrier #:

PART II: REQUESTOR'S POSITION SUMMARY AND PRINCIPLE DOCUMENTATION

Requestor's Position Summary "I was informed by my ombudsman, Linda Lewis, that a request for Medical dispute Resolution should have been filed within one year of date of services. This was the first I knew of this. My injury had been disputed and it wasn't until September 19 2007 that the hearing office determined that the Insurance Carrier had to accept my claim it was (proven to be a compensable injury.) My Attorney Blanca, Martinez with Ogletree law Firm never informed me of this deadline. I didn't find out there was a deadline until after the medical bills was turned over to a collection agency and I contacted the offices of injured employee counsel for assistance. In addition my Attorney did send my adjuster a letter back in February 12—08. For reimbursement for medication due to my worker comp claim and was denied by the adjuster. Most of my bills were denied by the carrier. I was depress and very stress with a lot Anxiety that cause me not to be able to respond on a lot of thing that was going on in my life at that time And I would like for you to please take this into consideration when reviewing my request for medical dispute resolution."

Principle Documentation:

1. DWC 60 package
2. Receipts
3. Medical Reports
4. Total Amount Sought $355.00

PART III: RESPONDENT'S POSITION SUMMARY AND PRINCIPLE DOCUMENTATION

Respondent's Position Summary: "Carrier respectfully submits its DWC-60 response with supporting documentation. These records are being provided pursuant to the rules and should not be used for any other purpose. Carrier also submits the attached Payment History indicating that a payment of $355.00 was issued to [injured worker] on 4/20/2010. As payment has been issued for the disputed services, Carrier's respectfully requests that this matter be dismissed, or in the alternative withdrawn upon HCP's receipt of this payment…"

Principle Documentation:

1. DWC 60 package
2. Payment Screen

PART IV: SUMMARY OF FINDINGS

Date(s) of Service	Denial Code(s)	Disputed Service	Amount in Dispute	Amount Due
02/07/07 – 01/07/08	N/A	Out-of-Pocket Expenses	$355.00	$0.00
Total Due:				$0.00

PART V: REVIEW OF SUMMARY, METHODOLOGY AND EXPLANATION

1. Neither party submitted EOBs for the disputed dates of service.

2. This dispute relates to out-of-pocket expenses with reimbursement subject to the provisions of Rule 133.270 and 134.503.

3. The Insurance Carrier's response indicated reimbursement was made to the injured worker. The injured worker was contacted; the injured worker confirmed that payment in the amount of $355.00 was received.

4. Pursuant the Division Rule 133.307(e)(3)(A) the Division concludes that this dispute no longer exits. As a result, the amount ordered is $0.00.

PART VI: GENERAL PAYMENT POLICIES/REFERENCES

Texas Labor Code Sec. §413.011(a-d), §413.031 and §413.0311
Texas Administrative Code Sec. §133.270, §133.307 and 134.503

PART VII: DIVISION DECISION

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code, Sec. §413.031, the Division has determined that the Requestor is entitled to $0.00 reimbursement.

		May 6, 2010
Authorized Signature	Auditor III Medical Fee Dispute Resolution	Date

PART VIII: : YOUR RIGHT TO REQUEST AN APPEAL

Either party to this medical fee dispute has a right to request an appeal. A request for hearing must be in writing and it must be received by the DWC Chief Clerk of Proceedings within **20** (twenty) days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. **Please include a copy of the Medical Fee Dispute Resolution Findings and Decision** together with other required information specified in Division Rule 148.3(c).

Under Texas Labor Code Section 413.0311, your appeal will be handled by a Division hearing under Title 28 Texas Administrative Code Chapter 142 Rules if the total amount sought does not exceed $2,000. If the total amount sought exceeds $2,000, a hearing will be conducted by the State Office of Administrative Hearings under Texas Labor Code Section 413.031.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.